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The Trouble with Morality: The Effects of 12-Step Discourse on Addicts' Decision-Making

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Abstract

Since its development in the 1960s, researchers have extensively scrutinized methadone maintenance treatment (MMT) as a medical response to heroin addiction. Studies consistently find that MMT is more successful than other treatment models in the reduction of opiate/opioid misuse, the transmission of diseases like HIV/AIDS and hepatitis C, and criminal arrest and conviction rates. Nonetheless, a significant portion of active and former heroin addicts view MMT negatively and—perhaps as a result—MMT is vastly underused. This study examines the effects of 12-Step discourses on the opinions and treatment decisions of active heroin addicts, addicts in MMT, and addicts in 12-Step treatment programs. The study finds the abstinence/morality based discourse of drug addiction and treatment is pervasive among addicts and their non-drug using relations and peers alike; moreover, addicts have internalized this narrative, oftentimes despite their own knowledge of MMT's success and positive personal experiences. The findings suggest that the dominance of abstinence/morality narratives contributes to MMT's poor reputation among, and low use rate by current and former heroin addicts and that the power of the dominant discourse is such that it produces a desire to buy into its values and tenets even when it is against the individual's interests to do so.

Keywords

abstinence; decisions; methadone; morality; stigma; treatment

Methadone is a synthetic opioid¹ primarily used to treat heroin and prescription opioid addiction: it can be used either to detoxify opiate addicts or to maintain the addict on a stable dose with the goal of enabling him/her to live a safer, more functional life. The latter form of treatment is called methadone maintenance treatment (MMT). Although MMT has been used and studied for over forty years with demonstrated success in reducing opioid misuse, prisoner recidivism, transmission of disease, and improving the overall quality of addicts' lives (Joseph, Stancliff & Langrod 2000), its efficacy has always been hindered by, among other things, a negative stigma that keeps this treatment from reaching a greater percentage of potential patients (Latowsky & Kallen 1997). While the stigma is undoubtedly created

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¹Opiates refer to alkaloids extracted from poppy pods and their semisynthetic counterparts which bind to the opioid receptors, while opiod is used to refer to any drug which binds to receptors in central nervous system (CNS) including synthesized drugs like methadone. However, this study uses the terms interchangeably.

and reinforced by a number of historical and cultural factors, one potentially powerful source is the prevalence of an abstinence and morality-based discourse that currently dominates mainstream conceptions of drug treatment/addiction and is exemplified by 12-Step organizations such as Narcotics Anonymous (NA). According to this discourse, MMT is not a valid form of treatment, and MMT patients are active “addicts” who are socially stigmatized and typically excluded from mainstream 12-Step programs (Glickman et al. 2006).

A great deal of literature examines the marked disparity between methadone’s demonstrated success as a form of drug treatment and its lack of availability to the addict population. Ethan Nadelmann (1996), in “Doing Methadone Right”, describes methadone’s recognized success among medical and scientific organizations, arguing that compared to any other treatment model, methadone’s results have been far superior. However, Nadelmann also points out that MMT has consistently been relegated to the medical gutter, in part because of a persistent stigma that marginalizes both patients and the treatment itself. Studies have also identified the impact of stigma on patient’s perception of and experience with treatment, finding that patients who experience minimal stigmatization are far more able to focus on the benefits of treatment (Gourlay, Ricciardelli & Ridge 2005). Additionally, researchers have argued that methadone’s negative perceptions are the result of discursive constructions reflecting the moralistic tone of modern America and the War on Drugs (Drucker & Clear 1999).

However, the potential link between the powerful abstinence/morality discourse² and addicts’ perceptions regarding MMT has never been closely examined. Although studies have demonstrated the existence and effects of stigma on MMT patients—which are decidedly negative—the relationship between addiction-treatment discourses and individual treatment choices has not been thoroughly explored. This study examines whether and how the discourse of morality-based, 12-Step programs affect addicts’ decisions regarding participation in MMT programs. To do this, this study examines three hypotheses. Hypothesis One predicts that the abstinence/morality discourse of addiction is dominant; more specifically, it predicts that this discourse is the one addicts are most exposed to and most likely to draw upon regarding addiction issues. Hypothesis Two predicts that addicts believe that the abstinence/morality discourse describes both methadone treatment models and methadone patients negatively. Hypothesis Three predicts that addicts’ internalization of the abstinence/morality discourse is associated with their treatment decisions, with those having internalized this discourse the most being least likely to try, or remain on, MMT.

BACKGROUND

MMT has been used as a drug treatment strategy since the late 1960s when Drs. Dole and Nyswander conducted clinical tests on its potential as a maintenance-based medication for treating opiate addicts (Joseph, Stancliff & Langrod 2000). MMT’s treatment philosophy is representative of the “medical model” of addiction, which holds that biological factors

²The abstinence/morality discourse refers to the previously described discourse that currently dominates mainstream conceptions of drug addiction, treatment and recovery, and is exemplified by 12-Step organizations such as NA.

determine addiction and that it can therefore be treated medically (Kleber 2008; Latowsky & Kallen 1997). This view differs sharply from the view of addiction held by 12-Step groups such as Narcotics Anonymous, who contend that addiction, though termed a “disease” is characterized by a moral/spiritual failing; from this perspective, MMT is viewed as a continuation of that individual’s addiction (Galanter 2007). Interestingly, although both groups use the term “disease” to describe the state of addiction, their conceptions of both the disease and of appropriate treatment methods differ sharply. While MMT’s proponents compare addiction to conditions like diabetes and argue that methadone serves a similar purpose to insulin for the diabetic (Joseph & Dole 1970), 12-Step group’s treatment consists largely of behavioral modification and the adoption of a spiritually-based philosophy. As such, this study refers to the 12-Step methodology as the “moral-spiritual model” and the biophysical explanation offered by MMT’s proponents as the “medical model.”

Extensive research documents methadone’s efficacy in treating opiate addicts and studies have consistently found reduced levels of opioid misuse, transmission of STDs, and prisoner recidivism among methadone maintenance patients (Ball et al. 1988; Kleber 2008; Werb et al. 2008; Marsch 1998; Nadelmann 1996). However, methadone is also shackled with largely negative perceptions among addicts, treatment providers, and the public that are associated with high dropout rates or addicts avoiding methadone-based treatment entirely (Fisher et al. 2002; Gourlay, Ricciardelli & Ridge 2005; Forman, Bovasso & Woody 2001; Zweben & Sorensen 1988)³ Methadone patients consistently report high rates of “stigma,” which Erving Goffman (1963) defined as “the situation of the individual who is disqualified from full social acceptance” resulting from a gap between an individual’s true attributes and societies expectations. Those patients who report feeling stigmatized have a more negative experience of and response to treatment (Schwartz et al. 2008; Gourlay, Ricciardelli & Ridge 2005; Stancliff et al. 2002). Additionally, studies have found that negative attitudes regarding MMT are pervasive among patients and that many enter the program with the immediate goal of “getting off (the program) as soon as possible” (Fisher et al. 2002; Zweben & Payte 1990).

Recent studies have suggested strategies for incorporating more evidence-based practices — which favor MMT—into drug treatment programs (Glickman et al. 2004; Matto 2004; Broekaert & Vanderplasschen 2003; Miller & Smith 1997). Research has also demonstrated that despite strict regulation, a significant portion of physicians would likely be willing to prescribe methadone to clients in mainstream pharmacy settings, thus suggesting a willingness among medical professionals to make this treatment more available (Coffin et al. 2006). Although 12-Step based treatment is still the dominant response to opiate addiction, an alternative strategy known as harm reduction has given momentum to groups who advocate for the “medical model” of addiction. Harm reduction refers to a variety of strategies and public health policies designed to minimize the potentially harmful consequences of high risk activities usually by taking a pragmatic as opposed to moral

³To some extent, addict’s negative perceptions regarding methadone-based treatment are due to structural issues such as the cost of treatment or inconvenience of the clinic system. However, their descriptions of the stigma experienced from family, friends, and society in general suggests that patients are experiencing sociocultural difficulties beyond the structural problems associated with the clinic system (D’Aunno & Pollack 2002; Sheridan 2008; Zule & Desmond 1998).

approach to the issue (Des Jarlais 1995), Studies found that incorporating more harm reduction policies, which are based on the medical model of addiction, decreases the perception that the individual in treatment is guilty of a moral “wrong-doing” (Ducharme, Knudsen & Roman 2006; Matto 2004; Broekaert & Vanderplasschen 2003).

Studies have also examined the social construction of illicit substances (Musto 1999) and treatment models. Using Foucault as a theoretical reference, these studies have argued that methadone-based treatment is caught between criminalizing and medicalizing discourses as evidenced by MMT patient’s strong desire for normalization (Bergschmidt 2004; Bourgois 2000; Foucault 1975). Corroborating this, Lee Garth Vigilant’s (2005, 2001) examination of 45 opiate-addicted individuals in MMT demonstrated that methadone patients are often torn between competing models of recovery, largely because of their outsider status as defined by the normative recovery practices of 12-Step groups like NA, and the lack of a clear alternative philosophy of “recovery” that is compatible with a methadone-based treatment model. However, the literature has yet to explore the link between the addict’s lack of enthusiasm for methadone-based programs and the larger abstinence/morality-based discourse that governs normative views on drug treatment and addiction issues. To some extent, this is the result of a long-standing neglect of the addict’s and methadone patient’s perspective by researchers and policy makers (Montagne 2002).

TOWARD AN INTEGRATIVE THEORY OF DISCURSIVE CONSTRUCTION

Foucault argued that discursive formations are an assemblage of statements that serve to organize and give meaning to a particular subject matter. In other words, discursive formations are the apparatus we use to interpret the world around us (Hall 1997). As applied to addiction, for example, the meaning of key terms like “sober” or “drug” as well as individual actions and events are all interpreted through, and contextually dependent on, the strength of various discursive formations. As such, if the abstinence/morality-based discourse is more dominant than any alternative viewpoints on addiction and treatment, then much of our understanding of that subject, both as individuals and as a society, is formed through the lens of that discourse.

In addition, Foucault’s (1969) work on the production of knowledge and the relationship between truth and power (truth-power nexus) is central to this study. For Foucault, truth and power are intrinsically linked and truth is simply the institutionally sanctioned, normative viewpoint. The dominance of abstinence-based groups like Narcotics Anonymous within the world of drug treatment enables their ability to sanction or determine how “truth” is defined. Foucault’s approach to the relationship between truth and power not only allows us to understand how the various “truths” about addiction are formed, but also establishes a framework for examining the lack of power among the addict population and the resulting inability of successful methadone patients to contest the dominant narratives with alternative discourses expressing their own viewpoints.

The theoretical foundation of this study deals with the ability of dominant discourses to influence behavior. As it relates to this study’s three hypotheses, a theory of discursive construction provides a model for understanding how opioid addicts internalize and

ultimately make behavioral decisions based on the tenets of the abstinence/morality discourse.

METHODOLOGY

Critical discourse analysis (CDA), developed primarily by Norman Fairclough, Ruth Wodack, and Teun van Dijk as a tool for uncovering and understanding the (re)production of power relations and inequality within language, is central to the theoretical and methodological aims of this Study (Blommaert & Bulcaen 2000). In contrast to other forms of discourse analysis, CDA concerns itself primarily with issues of power and inequality; it focuses on how to deconstruct the seemingly “natural” criterion of dominant discourses (Fairclough 1985; van Dijk 1993). In line with this, CDA usually takes a specific sociopolitical stance designed to empower marginalized groups by illuminating the role of discourse in the reproduction of dominance and inequality. Although CDA is a multidisciplinary approach and is not tied to a particular social theory or method of inquiry, its central tenets of power, dominance, and social cognition guide the approach used to analyze texts within this study. Specifically, using CDA helps to unmask the seemingly “natural” or “universal” aspect of the abstinence/morality discourse by revealing the process of social construction primarily accomplished through language and text. For example, CDA examines how specific terms such as “clean,” “abstinent,” and “recovery” serve to continually reconstitute a view of addiction/treatment that maintains the sociopolitical power of the abstinence/morality discourse and those who benefit from it.

RESEARCH STRATEGY

In order to examine whether and how abstinence/morality based discourses on drug addiction and treatment effect addicts’ opinions of and decisions regarding participation in MMT programs, this study analyzes interviews with current and former addicts. Interviews were chosen in part because of their ability to maintain subject anonymity and also to allow subjects a format where they can discuss a stigmatizing topic without subjecting themselves to any further stigma that might arise within focus groups. Additionally, interviews allowed subjects to speak freely regarding a particular topic as opposed to a more confining approach such as collecting survey data. These interviews, which examined addicts’ experiences and perceptions of addiction and treatment, were then coded using NVivo software in order to assess the three hypotheses described above. This study uses the individual as the unit of observation.

Data

This study uses a theoretical sampling strategy to produce data generated from one-on-one interviews with 16 individuals from four different groups. Each sample was drawn from four distinct populations: former heroin addicts now on MMT who are not using illicit opiates; former heroin addicts now on MMT who also use illicit opiates; former heroin addicts now in a 12-Step recovery program and not using illicit opiates; and current heroin addicts not involved with any treatment program. The 12-Step group was chosen to examine the origins of the dominant discourse and attempt to determine its strength within each individual. The two MMT-based groups were chosen to examine the effects of the discourse specifically on

those to whom it presents negative constructs and determine whether differences existed between compliant and non-compliant MMT patients. Finally, the active heroin user group was chosen to examine how the discourse affects both potential MMT patients as well as former MMT patients. Since the majority of long-term heroin addicts have had experiences with methadone programs and have likely abandoned them at some point, their feedback was important in determining whether the abstinence/morality discourse played a role in their discontinuation of MMT. In order to be considered eligible for the study, a subject must have been engaged in either drug use or treatment for at least one continuous year, and all subjects gave informed consent. Each sample group consisted of four subjects who were chosen primarily on a first-come, first-serve basis, with some considerations given to subjects' availability and/or location.

Subjects were recruited through flyers placed in locations specific to each group. The active heroin addicts and MMT patients who were using illicit drugs were located through flyers placed with the Chicago Recovery Alliance (CRA) and the Test Positive Awareness Network (TPAN), two grassroots harm reduction organizations that actively work with the addict community in Chicago. Methadone patients who were not using illicit drugs were recruited through flyers given to the Chicago Treatment and Counseling Center (CTCC), a local methadone clinic with four different locations throughout the city. Finally, 12-Step participants were recruited by visiting local 12-Step meetings and leaving flyers for anyone who might be interested. All subjects lived in the Chicago metropolitan area, and although there were no mechanisms included for ensuring demographic variance regarding age, race, or gender, the respondents were generally heterogeneous; the sample included nine men and seven women and while I could only surmise subjects' racial or ethnic background, my sample seemed relatively diverse, including Whites, Blacks, and Latinos. Additionally, recruiting flyers were placed in a diverse set of Chicago neighborhoods; this helped to ensure that the data was not reflective of only one particular treatment center or geographic location.

The interviews lasted anywhere from twenty minutes to an hour and a half and were usually done in the study rooms at local libraries. In some cases, the library had no study room and, since it was summer, those interviews were conducted outside. All subjects were informed that their identities would be kept confidential and advised that they could discontinue the interview at any time. Subjects were each paid \$20 for their participation. All interviews were conducted on a one-on-one basis except in one case where two subjects were leaving together and did not want to wait for one another; their interview was done together. All interviews were digitally recorded and then transcribed using F4 transcription software. Any references to individual subject names are pseudonyms. This project was approved by DePaul University's Expedited IRB Review Board.

Methodological/Data Limitations

The data collection phase of the study was subject to some limitations that could bias the empirical findings and conclusions of this study. Specifically, recruiting subjects through the CRA ensured that I would recruit a disproportionate amount of injection drug users as opposed to addicts who "snort" (inhale through the nose) or who take opioids in pill form.

Similarly, recruiting subjects for the compliant methadone users group entirely through the CTCC (although I distributed flyers to multiple locations in different parts of the city) could also bias the data collection. Using a wider variety of methadone clinics might have demonstrated differences between patients based on their particular clinic. Finally, the small number of participants is another limitation in the data collection phase of the study. I do not believe that any of these limitations affect the overall findings of this study, however, incorporating greater diversity and a larger sample in the data collection phase of a future study would be beneficial.

Methods

All of the interviews were analyzed using QSR's NVivo 8 software for qualitative data analysis. NVivo 8 is a software package that allows interview transcripts to be imported and the data coded for emerging themes and concepts relative to the study's hypothesis and research questions. In order to examine whether abstinence/morality-based conceptions of addiction and recovery negatively color addicts' perceptions of and thus decreases addicts' participation in MMT, this study organized data into groups that either supported or did not support the following three hypotheses.

- Hypothesis One predicts that the abstinence/morality discourse of addiction is dominant; more specifically, it predicts that this discourse is the one addicts are most exposed to and most likely to draw upon regarding addiction issues.
- Hypothesis Two predicts that addicts believe that the abstinence/morality discourse describes both methadone treatment models and methadone patients negatively.
- Hypothesis Three predicts that addicts' internalization of the abstinence/morality discourse is associated with their treatment decisions, with those having internalized this discourse the most being least likely to try, or remain on, MMT.

In many cases, addicts had multiple and often conflicting experiences and reference points to draw upon in their analysis of methadone's value in their lives. In these cases, the study attempted to determine if/when the abstinence/morality ideology superseded other evidence or the personal experience of the individual.

Inside/Outsider Status

Although it is generally considered wise for social scientists who are conducting research to reveal as little about themselves as possible, ethnographic research often makes that goal exceedingly difficult, and my case was no exception. I am a former heroin addict, a current methadone patient, and have done advocacy work for MMT and for methadone patients. While I had planned not to reveal that information to subjects, at least until the interview was complete, I found that in order to do so I had to either lie or avoid to the point of absurdity. As a result, I occasionally did reveal my former heroin use and my current participation in MMT.

When I mentioned—usually during small talk before the interview when the subject asked a question whose answer would necessarily involve my disclosing previous drug use—that I had been a heroin addict, the subject's whole demeanor changed and became noticeably

more relaxed. While I was still clearly viewed as an outsider due to being a student and an interviewer, I was at least considered “in the know” and someone who would likely not judge from the same standards as the “straight” world might. The result was usually far more beneficial than distracting. For example, once subjects knew my personal history, they were more apt to use slang without having to stop and explain its meaning or specific nuance and there were numerous moments when the subjects and I were able to laugh at something that would have been unnoticed or not funny to someone outside of the subculture of heroin users. There were also potential disadvantages to bringing up my previous drug use. Specifically, I noticed that once a subject was made aware of my history as a heroin addict, s/he assumed that I fell into the traditional role of a recovered addict currently professing the 12 Steps and thus maintained a moralistic outlook on drugs and drug addicts. As a result I occasionally noticed subjects emphasizing what they thought I wanted to hear, such as their most recent attempt to attend meetings or pursue abstinence-based recovery.

When I mentioned my status as a MMT patient—usually this occurred after I had already disclosed my history as a heroin addict—it seemed to have little effect on the subjects, many of whom had been in and out of methadone programs for years. Since subjects from the NA group often have clearly formed, and usually negative, opinions on MMT, I shared my MMT status with only one subject from this group. This subject began a dialogue regarding the pros and cons of MMT; however, once I explained that I did not want to unduly influence his responses but that I would be happy to speak more openly after the interview, he politely changed the subject. It is possible that this subject spoke more purposefully about the benefits of NA with the goal of encouraging me to attend meetings; however, I do not believe that this information brought about any substantive changes in this subject’s responses.

Throughout the course of the interviews, I often become aware of the subjects attempting to find out my particular stance on topics related to the study. I was not surprised by this since the conflict between abstinence-based groups like NA and harm reductionist models is well known and somewhat heated. In most cases, I was able to move through the interview without revealing what I considered to be too much personal information, and on the few occasions where the subject insisted, I offered to discuss my personal views after the interview. In no case did I reveal that I have done advocacy work for methadone patients and programs.

RESULTS

12-Step Hegemony

Hypothesis One predicts that the abstinence/morality discourse of addiction is dominant; more specifically, it predicts that this discourse is the one addicts are most exposed to and most likely to draw upon regarding addiction issues. Supporting this, responses demonstrated that the abstinence/morality discourse has become dominant over other competing narratives such as the medical model of addiction and that it exerts cultural and ideological power over addicts as well as their immediate networks of family and friends. This was evident in all four subject groups.

Firstly, the dominance of the discourse was evidenced throughout the subject's treatment histories by the preponderance of references to NA, Alcoholics Anonymous (AA), or other 12-Step recovery groups. In nearly every case, whenever the possibility of attending "treatment" became an option it was inevitably 12-Step based, and those who were seeking alternative treatment models were consistently faced with a lack of access and information. Subjects reported having always been familiar with groups like NA, and oftentimes they had family members who currently belonged to a 12-Step group. As Dennis, an NA member explained, "Well, it was known throughout my entire addiction about NA, you know; I had family members and friends who had been involved in it, I saw what it did in their lives." As another subject bluntly put it, "I didn't know nothing else."

In sharp contrast, information on methadone or other non-12-Step based treatment options was difficult for addicts to find, as Sarah's experience demonstrates.

When I initially started looking into treatment options I was going through periodic withdrawal ... So I went online and I googled everything I could learn about heroin addiction and treatment centers and withdrawal symptoms and the only thing I came up with were the traditional rehabs and the UROD [Ultra Rapid Opiate Detox] treatment which I'm sure you're familiar with—the rapid detox—which I would have looked at if it wasn't \$10,000, so yeah, it was insane and that led me to kind of give up on it for a couple of months.

In Other cases, addicts knew from experience that attending 12-Step meetings was not helping, but for lack of other options continued to try. When asked about her experience at Narcotics Anonymous and Alcoholics Anonymous meetings, Rene, who eventually got on a methadone program and is off illicit drugs, answered, "I've tried them all—I've been like fifteen times (laughs). To inpatient, detox, outpatient, and every time I've been in it, it's like once I'm free from the outpatient, on my own in a halfway house, it's like a week later I'm getting high again."

While 12-Step programs and messages inundated addicts, MMT was noticeable only through its absence. Subjects learned about 12-Step programs from their families, from media, in rehab, and in jail; in contrast, most subjects found out about MMT only from other addicts. Also, the addicts who told the subjects about MMT often had negative opinions, infused with inaccuracies and myths, about methadone. In most cases, methadone was presented as either a legal addiction or a short-term solution to withdrawal, with very few conceptualizing the program as legitimate means of recovery. As one NA member told me, "I thought about it. I wasn't thinking about quitting, just to keep getting high and not spend a lot of money, but I spoke to some older members who had been shooting dope for a long period of time and they told me that if I was gonna quit, go cold turkey and the methadone wasn't nothing but a crutch."

Mirroring and perhaps supporting the opposition between 12-Step programs' omni-presence and MMT's obscurity, addicts' families responded very differently to subjects' participation in 12-Step or methadone-based treatment. When I asked Dennis, who had alienated much of his family through the course of his addiction, how his family feels about his participation in NA, he happily exclaimed, "Oh they love me now! They love me now!"

In sharp contrast, family reactions to subjects' participation in MMT were usually far more negative. As one subject admitted, "I know they would (stigmatize me) if they knew. If they knew, whew, it'd be 'Shame on you, you don't need that! Go to church and ask the lord to deliver you'." In most cases, the family pressure is more subtle but nonetheless demonstrates both the dominance of abstinence-based treatment over medically-based models, and also that, through this dominance, abstinence-based treatment has been successful in promoting negative views of medically-based treatment and those who receive it. As Sarah, who has been on MMT and free of illicit drugs for many years, explains

Like my sister, she's very supportive, but she—she was on heroin, she's been clean for like four years and she moved to Alabama to get clean and did it that way and that worked for her, but she thinks that I can just ... Every once in a while she'll be like "You can get off that stuff, I know you can do it" and my brother-in-law says the same thing: "Why do even need that stuff?"

The same social hierarchy between abstinence-based treatment and medical models was also evidenced in the subject's dealings with government institutions or community organizations. Subjects who had served time in jail or prison reported either being given the opportunity or forced to attend 12-Step based drug treatment services while in jail, and one subject was currently under court order to attend NA meetings. In some cases, the dominance of abstinence-based treatment over medically based models extended to the methadone clinics themselves. Despite that fact that abstinence-based programs like NA explicitly deny methadone patients the status of recovering addicts, most methadone clinics either recommend or, in some cases, force patients to attend these groups. As one subject, Terry, reported:

There are signs up in the hallway, the forum where people congregate when they're waiting. They do have weekly meetings that are middle of the week, middle of the day ... It is now mandatory for anyone who gives a positive UA [urine analysis] to attend one of those meetings. There's also a sign up—I don't know who put it up—but there's a sign up there for a local AA chapter.

MMT Is Bad

Hypothesis Two predicts that addicts believe that the abstinence/morality discourse describes both methadone treatment models and methadone patients negatively. Although the responses from different subject groups address the topic in different ways, findings from all four groups support this hypothesis.

I examined the responses from the NA subject group to find out how members perceive medically-based treatment and, consequently, what messages are being sent to that community and society in general from the larger abstinence-based group. In each case, members expressed the opinion that methadone maintenance was not a legitimate form of treatment. These subjects argued that since MMT patients were not abstinent by the definitions of 12-Step groups, they were still using. In some cases, their views were supported by misinformation regarding the treatment itself: as Todd, one of the NA members explained:

For my understanding, it was designed to wean you off in small doses—to give you certain doses, and then at the end, the placebo effect, you was supposed to be drinking orange juice at the end. So people still been doing this five or six years, something is wrong with that. And I also think it's a government-run program and there's something wrong with that too and it's always in the inner city and it's also in the Black community is why too.

For the subjects in the NA group, MMT and all pharmaceutically-based treatments fail to address the “true nature” of addiction, which is a moral/spiritual problem that can only be addressed through complete abstinence, belief in a higher power, and participation in a 12-Step program. When I asked Dennis, a long-time NA member, about research that supports a medical interpretation of addiction and, thus, supports MMT, he responded: “You know, I don't really know too much about it, I base everything I say on my experience and those around me. But, you know, it's much deeper than that. It's spiritual by nature, there's no doubt about it. So it has to be dealt with on that level.”

Interviews with the other subject groups also provided evidence that addicts believe the abstinence/morality discourse describes methadone negatively. However, the responses of subjects who were in a methadone program were markedly different from the responses of addicts who were currently not in treatment. For the individuals currently in methadone maintenance programs (MMT patients who are not using illicit opiates and MMT patients who also use illicit opiates), the issue of methadone's perception in society was a significant source of difficulty in their lives. Nearly everyone in these groups admitted to hiding their status as a methadone patient to some degree for fear of either material reprisals, such as the loss of employment, or personal consequences, such as the loss of friends or a romantic interest. When asked about common perceptions of methadone patients, Vern explained: “Well, it's like for me, I don't tell my people at work, I'm embarrassed. I think they're gonna look at me in a totally different way, like a junky or whatever and you know I think, it may not cause I'm in a union, but I think it may jeopardize my job—if they got me into anything, I mess up and they're gonna blame me.” Laura's response demonstrates that individuals experience the same fears in more permissive work environments as well, “I feel the stigma is just terrible to the point where—I work at a job where people are very open about past addictions and what they've done, and I still don't tell anybody that I'm on methadone. I really feel like it's just one of those things where if you were to ever mess up it could easily be blamed on it, just something not related at all.”

Additionally, individuals in both methadone groups described methadone as being highly stigmatizing. This stigma, these subjects argued, made it difficult to remain in the program. While MMT patients experiences of stigma were worst at their Jobs and within personal relationships, methadone patients even encountered difficulties—due to stigma against methadone use—when trying to learn about the 12-Steps. As one subject, who was on methadone and using illicit opiates, described his attempts to visit NA meetings, “You don't want to tell anybody—especially when you go to meetings! Like I had a sponsor one time, she said ‘Don't tell anybody you're on methadone.’” The necessity of keeping their treatment a secret was a common theme among both compliant and noncompliant

methadone groups, and nearly every subject described some amount of anxiety over the stigma and the negative reputation they perceived methadone as having.

In contrast, while subjects in the active heroin users group were aware of the same issues brought up by the two methadone-taking groups, their different social positions both in the drug treatment world and society in general led them to interpret this information very differently. For the most part, active heroin users brought up methadone's stigma and negative reputation as reasons for avoiding the treatment and as evidence of their relative social superiority over the "junkies who're on meth [methadone] too" within the hierarchy of opiate addicts. Oftentimes, their explanations for avoiding methadone included urban legends and myths regarding its supposed dangers compared to heroin. As Charlie, a longtime heroin addict told me,

Like I mentioned earlier, I'm not really into the methadone itself cause I was told it's like another addiction, you know, so I feel if I take the meth, I'm gonna still use heroin—and also the withdrawal from methadone is worse than heroin. It also ... it eats, it gets in your bones, you know what I'm saying. You're bones ain't right, so that's why I'd never get into the methadone treatment myself.

Since the heroin users generally described methadone as a legal way of remaining high and not a legitimate form of drug treatment, many see it a way of discerning those who are really serious about quitting and those who are not. For example, when I asked one subject from the heroin addict group if he sees taking a medication for addiction as a moral failing he explained, "I see it as a moral failing because if you're serious about it, you're not gonna go through meth [methadone], you just gonna quit."

Treatment Decisions

Hypothesis Three predicts that addicts' internalization of the abstinence/morality discourse is associated with their treatment decisions, with those having internalized this discourse the most being least likely to try, or remain on, MMT. In other words, this hypothesis deals with the material consequences of the dominance and content of the discourse already analyzed. While each subject group showed evidence both of having internalized the abstinence/morality discourse and having it affect their treatment decisions, subject's impressions of methadone varied based on their group's relationship to and position within the discourse.

The NA subjects, who are the most positively described in the dominant treatment discourse (see the discussion of Hypothesis One), relied on the abstinence/morality narrative to support of their lifestyle and to denigrate the treatment choices of addicts in the other three subject groups. Each of these subjects referred to traditional 12-Step concepts such as complete abstinence and the belief in a higher power as evidence of their status as "recovering addicts" as opposed to those in methadone programs who are "seeking an easier, softer way" (which, interestingly, they characterize as being a negative aspect of methadone-based treatment). Additionally, they accused methadone patients of not looking at the "true nature" of their addiction, which the NA participants in this study described as essentially moral and spiritual.

For NA subjects, their very participation in NA suggests that they have adopted its tenets and value structure. Moreover, the dogmatic nature of 12-Step participants' responses speaks to the notion of internalization. For example, all of the individuals in the 12-Step group peppered their answers with phrases like "We learn through our program that addicts ... " or "Our program teaches us ... " which created a linguistic environment of dogmatism. Similarly, members' descriptions of joining the group suggested resistance and eventual surrender: as Dennis put it "I saw what it did in their lives, but I wasn't ready, so to speak, to surrender to it—but eventually I was brought to the point where I sought recovery through NA." Additionally, subjects from the 12-Step group often resorted to popular NA slogans such as "One is too many and 1000 is never enough" in order to illustrate their points, which made clear discursive links between the larger abstinence/morality discourse that informs groups like NA and the individual's own values and belief structure.

The abstinence/morality discourse rejects the lifestyle choices of addicts in the three remaining subject groups, however, intergroup differences emerged based on subjects' ability to resist the dominant narrative and counter it with their own alternative experiences. In most cases, subjects from all three groups believed the abstinence/morality model of addiction to be somewhat problematic, based on their own knowledge and experiences; nonetheless, the methadone patients who were not using illicit drugs, while still clearly influenced by the discourse, were generally more confident and better able to articulate their position in regards to medication-based treatment. Most were aware of the scientific data in support of the medical model of addiction and were confident regarding methadone's value in their lives. To some extent, much of the evidence regarding this group's internalization of the abstinence/morality discourse comes from their descriptions of the years before finding and coming to terms with methadone. Some subjects described years of failed attempts at 12-Step based treatment, all the while either being uninformed about methadone or avoiding it intentionally. Others found MMT, but continually tapered off the program only to quickly relapse. Additionally, while claiming that they were now comfortable with the idea of being on methadone maintenance, each compliant MMT subject admitted that eventually getting off the program was still a persistent goal, and despite the grim relapse rates for patients tapering off methadone, they would likely attempt it again at some point in the future. This demonstrates that even patients whose lives have dramatically improved as a direct result of MMT and who know the likely results of leaving treatment are still concerned enough with being "drug free" according to the standards set by the dominant discourse that they are regularly choosing to discontinue MMT, and in most cases quickly relapsing into active opioid addiction.

In contrast, the methadone patients who also used illicit drugs were far less able to resist the dominant conception of addiction and consequently their responses often sounded conflicted, confused, and very frustrated. These subjects were unable to reconcile their first-hand experiences with the messages they receive from the dominant culture on a daily basis. For example, Major, a noncompliant MMT patient who believes that methadone has had a positive impact on his life, described his motivation for trying methadone:

I just didn't like the feeling of, I didn't have a normal existence when I was just using opiates because I was on a swing thing, it was always like I was on a bad trip

—I was down and I was sick—I didn't have any normalcy. Sick and not, having money to buy dope and I felt that this was no way to live my life and I wanted some alternative and methadone was the alternative for me.

Although Major admitted to still using heroin when he has extra money, he clearly had far more control and lived a more stable lifestyle because of his participation in MMT. However, despite his own first-hand experience both in and not in methadone-based treatment, Major is still highly vulnerable to messages from the dominant culture, as his response to my question about the morality of taking methadone indicates:

So I know they say this, I don't know, in the past that methadone is a failure. I heard that in some sort of. In some media something, they say it's a failure, but as far as I've seen from experience it does work with some people. Yeah, it does but the thing is, I don't know what the long-term effects of this is so I don't want to stay on this any longer than I need to. I even considered detoxing a few months ago, but I had to stop. I stopped it because I wasn't ready, I wasn't going to be ready because I still wanted to do opiates, do some dope you know. I notice that some clients I've talked to, they go in and they think they're ready and they go and detox—I'm not at that point yet, but I would hope to be soon.

Although Major recognized the dramatic improvements in his life and attributed those changes to being on MMT, his responses displayed his conflicted relationship to methadone and demonstrate that he had internalized parts of the abstinence/morality discourse. He also stated that he planned to discontinue treatment as soon as possible, which he attributed directly to messages from the media. Later in the interview, when Major explained his reasons for wanting to taper off of methadone, which he described as becoming "completely sober," he tellingly used traditional 12-Step phrases to justify his view, "Everything wasn't as it appeared when I was always self-medicating and I'd wonder what I was hiding from. Then I'd say 'Am I hiding from life on life's terms?'"

Vern, also in the noncompliant methadone group, embodied the same sense of defensive insecurity regarding MMT. Throughout the interview, I kept sensing that he was grateful and relieved to be on the program, but felt that he *should* want to taper off because of methadone's negative reputation. When I asked if getting off methadone was a goal he immediately became flustered,

Oh yeah, that is a specific goal, but I'm saying, why ... I have a question: do we always have to ... there's no way off, we gotta get sick ... I would love to, but I know I'd be sick 'cause even on Sunday in the morning I think of my bottle [Patients typically get one take home bottle of methadone every week—usually on Sunday—allowing the patient to not have to attend the clinic that day] ... I mean, I do, but I don't. Look at, if I don't get high. If I'm not on methadone and I'm not getting high—one thing, I'm sick and the other thing I'm bored to death, and then one day something happens and you use. I don't want to go there.

Fear of being pushed back into the world of active addiction was palpable in Vern's case and a common theme, especially among the methadone patients who still use illicit drugs. These subjects felt they needed their medication in order to function on a daily basis, but

also believed that they should not need it. In fact, they believed they should be doing everything possible to get off methadone.

Vern's concerns over being on MMT had also caused him to insist on keeping his daily medication dose low, which could explain his continued desire to use heroin. Despite the fact that his clinic counselor had recommended a dose increase (the common way of handling a patient who is still experiencing cravings and the ability to feel other opiates), Vern continued to refuse, and tried to convince his counselor—who had the monthly results of Vern's failed drug tests—that he was not using heroin. Unfortunately, Vern's susceptibility to messages from the dominant culture and his inability to resist them with his own knowledge and experience had significantly hampered the effectiveness of his current treatment.

Finally, the active heroin addicts group also demonstrated significant internalization of the abstinence/morality discourse and despite the fact that they were not currently living by its tenets still held its core values to be true. This was evident primarily through their general opinions on drug use and drug treatment, which nearly always coincided with the outlook and philosophy of 12-Step and abstinence-based organizations. For example, most of the subjects from the active heroin addicts' group viewed addiction in moral terms and even downplayed evidence supporting a medical or scientific view of addiction. When I asked Jane if she believed that addiction was the result of poor moral choices or something more related to individual biological causes, she replied,

Just my personal opinion, poor moral choices. Of course I believe it's a poor choice anytime you reach out for any type of chemical whether it is a drug or alcohol to cope with your feelings. 'Cause that was the issue for me—I was trying to forget things that happened to me in the past. Brain chemistry? Maybe not as much of a brain chemistry, although I have noticed that people who have a tendency to be depressed a lot are gonna be the first one I believe, in my opinion of course, to reach out for a drug.

Not only did she focus specifically on morality but her view of her own addiction as being a coping strategy against past abuse was clearly rooted in the view of addiction espoused by 12-Step groups. This is not to suggest that Jane had not been abused or even that her interpretation was wrong in any way, only that she conceptualized addiction and her own personal experiences through the lens of the abstinence/morality discourse⁴.

Similarly, subjects from the active heroin users group tended to view complete abstinence as the only acceptable goal of drug treatment and sometimes suggested that happiness was impossible without it. When I asked Jane whether abstinence or quality of life was more important, she responded:

So I believe maybe it's a tricky question because one comes with the other—the abstinence comes with the quality of life, therefore to me, once I would get clean,

⁴Cause and implied treatment can be distinct. The experience of trauma does change brain chemistry (there is ample evidence of this), creating a medical reality that can be treated medically. Thus, stating something has an environmental cause does not preclude seeking a medical cure.

my life would improve, therefore the quality of my life would improve, kinda one goes with the other. *One cannot happen without the other.* You can't have a good, quality life without sobriety.

Later in the interview, she expanded on her reasons by using a well know 12-Step theme in support of her argument,

You know, one always leads to another, you know once you get, say I'm clean for three years right? And then I go to somebody's birthday and I have a glass of wine and I get that euphoric feeling, therefore it makes me feel more at ease, it makes me think "You know if I try a little bit of something else, it won't hurt me" so therefore you start spiraling down all over again and they say every time you fall, you fall a little bit lower, so I believe that once you leave it alone, you better leave it alone cause it's not gonna take you any better place.

In many ways, subjects from the active heroin users group seemed a lot like subjects from the noncompliant methadone group once they had left treatment, and not surprisingly, all but one had been on a methadone program at some point in the past. They maintained positive views on 12-Step based treatment and abstinence/morality discourses and, inversely, held negative views on methadone-based treatment and the medical/scientific discourse. Knowing this, it is hardly surprising that they were not currently in MMT treatment and had no plans to return. As one subject told me, "I would rather just try to detox off the dope."

DISCUSSION AND CONCLUSION

This study examined the discrepancy between methadone's demonstrated value for treating opiate addiction and its general lack of use among addicts by speaking directly to active heroin addicts, addicts in MMT who still use illicit drugs, addicts in MMT who do not use them, and addicts in NA who do not use them. The study has three major findings. First, subjects from all four groups relied heavily on the abstinence/morality discourse popularized by 12-Step programs when talking about addiction and treatment. Second, addicts believe this narrative positions MMT and, thus, methadone patients negatively. Finally, reliance on an abstinence/morality-based narrative, which denies methadone the status of "drug treatment," is associated with subjects' avoidance of MMT.

Subjects' descriptions of their exposure to various forms of drug treatment made it clear that addicts were far more often exposed to abstinence-based therapies. Moreover, these types of treatment were held in far greater regard by the immediate network of family and friends surrounding the individual than methadone, which was nearly always seen as a means of continued addiction and sometimes considered even worse than that subject's existing heroin habit. Not surprisingly, addicts were well aware of methadone's negative reputation within the world of drug treatment and society, and their responses indicated that they had internalized aspects of the dominant viewpoint either by avoiding methadone-based treatment entirely or engaging in a halfhearted and guilt-ridden attempt at treatment, which, although often a force of stabilization in the addict's life, is quickly abandoned because of that individual's own internal misgivings regarding the treatment. Subject's responses, particularly the individuals on MMT who still use illicit drugs, indicate that insecurity

about MMT leads patients to refrain from fully committing to the program and either leaving entirely or continually vacillating between MMT and active addiction. Although individuals from the compliant methadone patients group did demonstrate the ability to resist the dominant narrative with a thorough knowledge of the subject and their own personal experiences, their universal goal of eventually leaving the program suggests that their treatment decisions also have some relationship to the popular views on methadone and methadone patients.

POLITICAL IMPLICATIONS

Although this study is an examination of the discursive formations that govern drug addiction and treatment and not a structural examination of the policies that govern methadone, the two are inseparable and continually influence one another. The political implications of this study are that drug treatment services are often conceptualized entirely on a mono-discourse that only recognizes a narrow interpretation of abstinence-based “recovery” as having value to the opioid addict. Furthermore, decades of prohibitionist and abstinence-based attempts at treating opioid addiction have often failed to meet the needs of addicts, and by failing to provide for alternative discourses that recognize the pragmatic and medical benefits of MMT the government has allowed this discrepancy to continue. MMT has consistently demonstrated its ability to reduce opiate use, transmission of disease, and criminal arrest and conviction rates and the fact that addicts not only consciously avoid it, but are also uninformed and misinformed about it—as evidenced by the referencing of urban legends such as methadone’s supposed ability to rot bones—suggests a critical lack of communication between government agencies who oversee addiction services and the addicts they are supposed to be serving. As such, government agencies need to work towards creating a discursive change that reframes the conceptualization of drug addiction and treatment in favor of MMT and other medically-based treatment options with demonstrated results.

If future research corroborates the preliminary findings of this study, timely recognition by organizations that are in a position to create policy is called for. These organizations, like the Substance Abuse and Mental Health Services Administration (SAMSHA), National Institute of Health (NIH) and the National Institute on Drug Abuse (NIDA) should work to better inform individual councilors, and most importantly, addicts and their families. Moreover, government policies must provide greater support to alternative models generated from a harm-reduction perspective. If the results show a large number of potential candidates for MMT programs are avoiding them because of their perceptions of this and other forms of treatment, then the means and content of the government’s message to opiate addicts may need to be reexamined to conform to more evidence-based practices. Including MMT as an option for criminal diversions, programming inside jails and prisons, and probation and parole drug treatment requirements would be a positive step. The political organizations who create and administer policies regarding drug treatment and addiction by default participate in creating “truths” about addiction that once sanctioned by government institutions will be taken for granted. By offering a more comprehensive, evidence-based view of the various treatment options, local organizations who deal with opiate addicts and addicts themselves

would have a better means of understanding the construction of “truths” regarding either treatment model, and be better equipped to make appropriate choices.

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